Annex 12

Summaries of Selected Cases Concluded by Full Investigation

AGRICULTURE, FISHERIES AND CONSERVATION DEPARTMENT (AFCD)

Case No. OMB 2002/1163

AFCD – handling of lost dogs – dereliction of duty on the part of an Animal Management Centre, such that the complainant could not reclaim her lost dog before it was euthanised – substantiated

The complainant lost a three-legged dog in February 2002. She called an animal management centre (Centre A) under AFCD on 19 and 20 February to enquire, but the staff there said there was no record of such a dog. On 23 February, the complainant learned from a voluntary organisation that it had handed over a three-legged dog to Centre A on 17 February, but the dog had then been euthanised. The complainant thus went to Centre A to enquire again, but the staff insisted that there was no three-legged dog, nor any record of one. However, when the complainant called Centre A on 25 February, staff there confirmed that a three-legged dog had been euthanised on 22 February.

2. The complainant alleged that the staff at Centre A were derelict in their duty. As a result, she could not reclaim her pet dog before it was euthanised.

3. AFCD would normally fax details of animals reported lost to alert its four animal management centres (AMCs). Staff A at AFCD headquarters called Centre A upon receipt of the complainant's first call. However, the staff on duty there could not provide an answer. Staff A also sent a fax to all AMCs to enquire about the dog. Receipt of the fax document was recorded at two AMCs but not Centre A. In response to our inquiry, staff B (the only staff on duty at Centre A at that time) also claimed that he had not received any fax or telephone enquiry about a three-legged dog.

4. Towards the end of our investigation, AFCD provided records from its mobile telephone service company, which showed that staff A did call Centre A. The Department could not ascertain whether his call had been answered by a staff member other than staff B. In any case, that staff member neither followed up nor recorded the enquiry.

5. Regarding the complainant's second telephone enquiry on 20 February 2002, AFCD's first two replies, based on an investigation report by a staff C at Centre A, contained details of events which coincided with those given by the complainant, i.e. Centre A did receive the enquiry. However, in its third reply to us, the Department cited a "further investigation" report by staff C and denied receipt by Centre A of any telephone enquiry about a three-legged dog, saying that the first two replies were based only on information provided by the

complainant and had never been confirmed by staff at Centre A. After carefully examining the initial investigation report by staff C and, on balance of probability, we were satisfied that the complainant did call Centre A the second time. The staff answered her enquiry based on the information at hand and did not record the call as a reported loss.

6. AFCD provided us with contradictory information and overturned its earlier comments. Though there was no evidence that it had misled us intentionally, we had reservations over its careless attitude and practice. Moreover, the documents provided by AFCD and the voluntary organisation about the dog contained no description of it being three-legged. Their records were obviously too brief and rough.

7. On the other hand, had the dog been implanted with a microchip or carried some information on the owner, AFCD would have been able to trace its owner immediately and the outcome would have been different. The owner of the dog was, therefore, partly responsible for this incident.

8. Overall, this complaint was substantiated.

9. To avoid recurrence of a similar incident, AFCD had, in view of its insufficient internal communication, instructed its staff to note down the identity of the staff answering their calls. It had also issued clearer and more detailed guidelines on the handling of enquiries on lost dogs and AMC procedures for receiving and disposing of dogs. Meanwhile, it started using the Integrated Call Centre system, through which many reports of lost dog have been referred to the AMCs.

10. The Ombudsman recommended that AFCD send an apology to the complainant and take action to improve the checking of information on dogs submitted by voluntary organisations, handling reports on lost dogs, keeping of animal records by AMCs, supervision of staff performance as well as its system of handling and investigating complaints.

11. AFCD accepted the recommendations.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

Summaries of Selected Cases Concluded by Full Investigation

AGRICULTURE, FISHERIES AND CONSERVATION DEPARTMENT (AFCD) AND EFFICIENCY UNIT (EU)

Case Nos. OMB 2002/3586
OMB 2003/0209

AFCD – animal collection service – (a) impropriety in collecting the dogs surrendered by the complainant; (b) excessive use of force in the process, strangling some of the dogs; and (c) providing the complainant with wrong information as to the time of euthanasia so that she lost the chance of reclaiming her dogs – partially substantiated

EU – handling of enquiry – Integrated Call Centre failing to handle the complainant's enquiry properly – unsubstantiated

The complainant requested AFCD to collect six dogs she wanted to surrender. She alleged that the Animal Management Team (the Team) did not bring enough cages so that one of the puppies had to be put into the same cage with a strange big dog and was bitten to death. Furthermore, the Team had used dog-catching poles to loop and lead away three puppies, cruelly strangling them.

2. Later, the complainant called the AFCD hotline several times and indicated her intention to reclaim the dogs, but was told that all her dogs had already been euthanised. She said that she had not signed any documents to authorise the Department to euthanise her dogs. Moreover, different AFCD staff gave her different answers as to the time of euthanasia. Their misleading information had cost her the chance of reclaiming her dogs.

Complaint (a)

3. AFCD pointed out that the Team had brought three large dog cages and a small one for the occasion. Two of the large cages had been occupied by two dogs collectedfrom elsewhere that day. After putting two of the dogs surrendered by the complainant into two empty cages, the Team suggested that they return with more cages the next day for her four remaining dogs. However, the complainant insisted that the six dogs be collected together. So, the Team put a puppy into the cage with a sick big dog and followed the complainant to her premises to collect the other three which had to be caged with other dogs.

4. The Department clarified that except for biter dogs, which must be segregated, there was no specific rule to put each dog in a separate cage. The Team leader claimed that he had kept an eye on the cages. There was no fighting among the dogs in the same cages and no puppy bitten to death.

5. Nevertheless, in view of the complainant's express request for collection of six dogs, we considered that the Team should have brought enough cages. Hence, they had not properly prepared themselves for the collection.

6. The Team leader stressed that he had explained to the complainant that her dogs would be euthanised and had asked her to sign the Authorisation of Animal Disposal form (Authorisation). However, claiming that she was not feeling well, she did not sign it. So they left with the dogs. AFCD considered this acceptable as the complainant, though agitated at the time, had given verbal consent to the Department to handle her dogs.

7. We considered that signed Authorisation to be required as it would avoid dispute and prove that the owner knew that the animals would be euthanised. It was improper and unwise of the Team to collect the complainant's dogs without her signing the Authorisation. Moreover, AFCD should formulate detailed guidelines on animal-collection procedures.

8. This complaint point was substantiated.

Complaint (b)

9. The Team leader stated that they did not use excessive force while leading the three puppies away with dog-catching poles, let alone strangled them.

10. Records in the AFCD Register for Surrendered Animals showed that the six dogs of the complainant were still healthy upon arrival at the Animal Management Centre. Before performing euthanasia, the veterinary officer did not find any of the dogs injured or dead. This complaint point was therefore unsubstantiated.

Complaint (c)

11. Next day, the complainant called the AFCD hotline and left a message. AFCD staff returned the call, learned that she wanted her dogs back and told her the dogs had already been euthanised that morning before she called. The complainant telephoned the hotline again several times and went to AFCD to enquire about her dogs on the following days. Two other AFCD staff told her that her dogs were euthanised in the afternoon of that day. She considered herself to have been misled by inaccurate information and thus failed to reclaim her dogs.

12. Our investigation confirmed the time of euthanasia to be in the morning after collection and before the complainant's first call. So, the two AFCD staff had indeed provided wrong information but this did not affect her chances of reclaiming her dogs.

13. This complaint point was partially substantiated.

14. The "AFCD hotline" was actually answered by staff of the Integrated Call Centre (ICC) of EU under the Government Secretariat. The complainant claimed that when she called the hotline the day after her dogs were collected, she had indicated her intention of reclaiming them. However, the request was not registered in the e-mail sent by ICC to the Department. She suspected that ICC had not handled her enquiry properly.

15. Information from EU and the tape of the telephone conversation showed that staff of ICC had accurately registered the complainant's enquiry. There was no impropriety in their handling process. The complaint against EU was unsubstantiated.

General Observations

16. Overall, this complaint was partially substantiated.

17. AFCD issued a verbal warning to the staff who had conveyed the wrong message and apologised to the complainant both for improper collection procedures and for the conflicting information in reply to her enquiry. It had also issued new guidelines on animal collection procedures indicating that the Animal Management Team must get signed Authorisation from the owner of the animals. Meanwhile, the Animal Management Centre had acquired some collapsible dog cages for emergency needs.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency, and pointing out the facts when public officers are unjustly accused.

BUILDINGS DEPARTMENT (BD)

Case No. OMB 2003/0981

BD – advisory letters and removal orders – failing to issue advisory letters and removal orders concurrently on three items of unauthorised building works in the same property – partially substantiated

The complainant lodged a complaint alleging that between June one year and March the following year, BD had issued separate advisory letters and removal orders on three different items of unauthorised building works (UBW) in the same property. As a result, he could not arrange for concurrent demolition, resulting in a waste of his time and money. The

UBW were flower rack and canopies attached to the external wall, a rooftop structure and an outward swinging metal gate obstructing the means of escape.

2. BD explained that the three UBW came under the purview of three different sections of the Department : Existing Buildings Division (EB Division), Illegal Rooftop Structures Unit (IRS Unit) and Fire Safety Section (FS Section).

3. In May that year, FS Section issued advisory letters to all flat owners of the complainant's building advising them to "remove any UBW". In June, IRS Unit and EB Division by coordination issued an advisory letter to demolish the rooftop structure and an order to remove the UBW attached to the external wall. In November, FS Section issued an advisory letter on the complainant's outward swinging metal gate. Finally, IRS Unit issued a removal order on his rooftop structure in March the following year.

4. BD observed that the advisory letters and removal orders had been issued to the complainant about May and June that year. The sections concerned had followed the departmental instructions in handling the case. They had coordinated their actions to minimise the inconvenience to the complainant.

5. This Office considered that EB Division and IRS Unit had worked together in issuing their orders and advisory letters concurrently and that such coordinated efforts should be encouraged. However, FS Section had not issued its advisory letters at the same time and the contents of those letters were vague. As an enforcement agent, BD should try to assist owners to understand statutory requirements for compliance. BD should also minimise the nuisance to owners and avoid waste of their resources in ensuring public safety and protecting property.

6. The Ombudsman considered the complaint partially substantiated.

7. The Ombudsman made the following recommendations to BD –

(a) to formulate internal guidelines for clear instructions to the sections on coordinating the issue of advisory letters and orders concurrently to minimise nuisance to the public; and

(b) to give clear instructions to the parties concerned when issuing advisory letters on demolition of UBW.

8. BD implemented the above recommendations.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

Summaries of Selected Cases Concluded by Full Investigation

BUILDINGS DEPARTMENT (BD) AND ENVIRONMENTAL PROTECTION DEPARTMENT (EPD)

Case No. OMB 2003/2024
OMB 2003/2025

BD and EPD – removal orders and advisory notice on removal of asbestos-containing materials – failing to synchronise issue of removal orders and advisory notices on unauthorised building works in the same property – partially substantiated

The complainant lodged a complaint against BD and EPD for poor coordination in issuing orders and notices to remove unauthorized building works (UBWs) on her premises. She alleged that BD had issued a removal order against a flower rack on her premises in January, while EPD issued a notice regarding removal of a canopy containing asbestos on her premises in April of the same year. She would, therefore, have to incur additional expenses to remove the canopy as the scaffolding erected on the external wall of her premises for removal of the flower rack had already been taken down.

2. Both BD and EPD emphasised that their coordination in advising relevant property owners about the removal of asbestos-containing UBWs in blitz operations was good. Their arrangements enabled owners to know the legal requirements for removal of materials containing asbestos before they started to remove UBWs suspected to have such materials.

3. The subject premises was one of the target buildings for the blitz operation 2001 of BD. EPD surveyed those target buildings for the presence of UBWs containing asbestos. BD requested the complainant to remove only a flower rack on her premises. No action was required on the lightweight canopy since its dimensions and construction materials did not exceed the tolerable limit. However, as the canopy contained asbestos, EPD served to the complainant a notice conveying the requirements under the Air Pollution Control Ordinance, in case she demolished the canopy. The notice was advisory in nature and did not order removal of the canopy.

4. EPD had reminded the complainant of the said legal requirements twice before the notice, by attaching leaflets “Asbestos Removal of UBW” to BD’s advisory letter and demolition order.

5. This Office considered that Government departments had a duty to assist and facilitate the public in complying with Government regulations or statutory requirements. In this case, even though the two departments were enforcing different legislation and had different concern over the canopy, the time lapse between BD’s order and EPD’s notice could have been

shorter if the two were better synchronised. EPD's notice, specifying the location of the asbestos, would help the complainant to decide on her removal plan only if served in time.

6. The Ombudsman considered the complaint partially substantiated.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

BUILDINGS DEPARTMENT (BD) AND LAND REGISTRY (LR)

Case Nos. OMB 2002/3267
OMB 2002/3268

BD – correspondence address – failing to update the complainant's correspondence address as requested – partially substantiated

LR – correspondence address – refusing to update the complainant's correspondence address – unsubstantiated

The complainant alleged that BD had failed to update his correspondence address as requested whilst LR refused to update it for him. He considered both departments shirking their responsibilities.

2. In 2000, BD sent two letters to the complainant for urgent removal of a canopy on the external wall of his premises. As the letters had been sent to his old address, he wrote to BD to request an update of his correspondence address. BD thus updated its records and sent its letters to the new address.

3. However, in 2002, when BD issued an order for removal of unauthorised building works (UBW) attached to his premises, the letter was again sent to his previous address. On his enquiry, BD staff told him that information on the owner had been provided by LR. He then called LR to request a change of his correspondence address but LR refused, stating that it was BD's responsibility to update the records.

4. BD explained that upon receipt of the complainant's request for updating his correspondence address, it was recorded in the file concerned. As the urgent removal of the canopy in 2000 and the order for removal of UBW in 2002 were on two separate files, handled by different units so that the officer who issued the latter order was not aware of the change of address. The Department regretted the inconvenience caused and reminded staff to check

whether individual owners had changed their correspondence addresses when handling old files.

5. In July 2002, BD implemented the Building Condition Information System (the system) on a trial basis. The information on owners provided by LR and the latest advised by owners had been input into the system. The Department would also check the records in the system before issuing any orders. BD has since updated the complainant's correspondence address in the system.

6. On the other hand, Land Registrar was not empowered by the Land Registration Ordinance to change, or even update, any information on the registration documents. To avoid similar complaints, LR held a meeting with other departments to remind them that owners' addresses in the registration documents might not be the most up-to-date. A remark to that effect would be added to the Reports-on-Title provided to various departments concerned and the registration date of the documents would also be indicated.

7. This Office considered that LR had executed its duties in accordance with the law and was not shirking responsibility.

8. In this light, the complaint against BD was partially substantiated and that against LR unsubstantiated. Overall, The Ombudsman considered the complaint partially substantiated.

Conclusion

9. The Ombudsman made the following recommendations to BD –

(a) to remind staff to update information in the system as supplied by owners as soon as possible and to explain to staff LR's responsibilities;

(b) to instruct staff to review the relevant files and the records in the system upon receipt of LR's Reports-on-Title to ensure the accuracy of the information, paying particular attention to the need for updating the information, or not, before issuing any order;

(c) to explore the feasibility of obtaining the owners' latest address through other channels; and

(d) to urge staff of different units to stay alert and those officers with related jobs should enhance their communication and coordination.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

Annex 12

Summaries of Selected Cases Concluded by Full Investigation

DEPARTMENT OF HEALTH (DH)

Case No. OMB 2003/0422

DH – chips allotment system – (a) being unfair in allotting chips at an out-patient clinic; (b) failing to set up criteria for issuing additional chips; and (c) failing to follow up a complaint properly – partially substantiated

The complainant was waiting in seat No. 35 for consultation at a general out-patient clinic under DH at 12:30 p.m. 38 consultation chips were to be allotted and distribution was to start at 2:30 p.m. However, when patient No. 33 was registered, the clinic staff informed those waiting in the queue that all the chips had been allotted.

2. The complainant tried to reason with the staff but learned that some patients queueing in front had taken more chips on behalf of others. This resulted in those waiting at the end of the queue not getting their chips. When she asked for issue of additional chips, she was assessed as not so seriously ill as to justify such request. Later, she complained to the nurse for the unfair allotment of chips but it was not properly followed up by the clinic.

Complaint (a)

3. Consultation chips were allotted on a "first come, first served" and "one person, one chip" principle, established by DH clinics. However, if a person could produce the identification documents of a sick relative and offer reasonable grounds for his failure to come and queue personally for the chip, that person would be given one more chip. The number of chips to be allotted each day would be displayed on the notice board in every clinic. Before the allotment started, the clinic staff would count the number of people queueing and the proxies. Those who would not have a chance would be alerted as soon as possible so that they might decide whether to continue waiting. The numbered seats in the clinic were meant only to facilitate orderly queueing and not to coincide with the number of the chips.

4. This Office considered that since a numbered queueing zone was designated in the clinic, the intention was surely to inform those waiting whether they could get a chip. However, as the Department permitted a person to take more than one chip, a person apparently within the zone would still have to wait until the actual distribution of chips before he would know if he could get one. Moreover, DH lacked a monitoring mechanism to prevent those arriving earlier from taking a consultation chip for a latecomer.

5. Complaint (a) was, therefore, substantiated.

Complaint (b)

6. Although the number of chips for distribution had been set, patients in urgent need failing to obtain a chip would have their conditions assessed by medical staff to decide whether an additional chip should be issued. In this particular case, the medical staff at the clinic had assessed the complainant's conditions following the established practice. This Office would not comment on this as it was a question of clinical and professional judgment.

7. Complaint (b) was, therefore, unsubstantiated.

Complaint (c)

8. In response to the complainant's request, a nurse and a doctor had met her to explain the principle of the allotment system and to advise to contact their Client Relations Unit for lodging a complaint.

9. As the medical staff had handled her request for an additional chip and her complaint properly, complaint (c) was unsubstantiated.

Conclusion

10. Overall, this complaint was partially substantiated.

11. Since 1 July 2003, Hospital Authority (HA) has taken over the general out-patient clinics under DH and continued the chips allotment system. DH and HA undertook to follow up The Ombudsman's recommendations as follows –

(a) to adhere strictly to the "one person, one chip" and "first come, first served" principle for the queueing system;

(b) to review the existing arrangements so that those who have arrived will be allotted chips before any remaining or additional chip is issued on individual request; and

(c) to implement the registration system prudently to prevent any improper transfer or resale of additional chips.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

Annex 12

Summaries of Selected Cases Concluded by Full Investigation

EDUCATION AND MANPOWER BUREAU (EMB) (formerly EDUCATION DEPARTMENT (ED))

Case No.OMB 2002/4649

ED/EMB – regulation of private schools – (a) delay and abuse of power in unreasonably rejecting school fee applications; (b) delay in processing applications for teaching permits; (c) attempt to upload the school's privileged information onto the ED website without proper authority; (d) failure to action against illegal schools; and (e) lack of consultation before introducing new regulatory measures – partially substantiated

The complainant was the principal of a tutorial school. In May 2001, ED approved applications from the school to collect fees for its courses by six instalments instead of the standard fee structure of 10 or 12 instalments stipulated in Regulation 62 (R62) of the Education Regulations. On 1 June 2001, the Education (Amendment) Ordinance 2001 (EAO 2001) came into effect and amended R62 so that the fee for a course shall be collected on an equal monthly basis. The then ED, therefore, required all schools to submit particulars of course fees for 2001 / 02 for approval and for issue of new Fees Certificates.

2. The complainant, responding to this requirement, applied for new Fees Certificates for both existing and new courses based entirely on the fees regimens approved in May 2001. ED turned down the applications for non-compliance with the new R62. The complainant felt aggrieved that ED had failed to explain the reason for not granting him exemption as in May 2001.

3. The complainant alleged that an ED officer, at a meeting in November 2001, had without authority offered a "grace period" for him to keep the existing fee structure for one year. He regarded the offer as inducement for him to give up the fees regimens already approved and abuse of power.

4. The complainant further alleged that ED took an unduly long time to process his applications for employing teachers from overseas. In one case, ED took almost a year to approve an application.

5. In May 2002, ED requested all private schools to provide information on facilities, faculties and insurance policies. Schools were told that part of the information would be uploaded to the ED website for public viewing. The complainant contested that ED had no statutory authority to publish such information without consent from schools and ED's omission to mention this was tantamount to deception.

6. The complainant also alleged that ED had failed to take enforcement action against illegal schools and to consult those in the trade properly prior to the introduction of EAO 2001.

7. Upon dissolution of ED in February 2003, EMB took up all its functions.

Complaint (a)

8. EMB explained that private schools had difficulty complying with the old R62 as students enrolled throughout the year and some courses were shorter than ten months. Moreover, closure of several private schools during the year 2000 / 01 had resulted in parents and students suffering loss of fees. The new R62, requiring schools to collect fees by equal instalments, safeguarded the interests of parents and students as well as providing flexibility to schools.

9. This Office considered that while EMB should not revoke the fees regimens approved in May 2001 for the existing courses, rejection of applications for new courses with fees regimens not compliant with the new R62 was legitimate and proper. However, ED should have explained to the complainant that the exemption granted in May 2001 was at the discretion of the Director of Education who, in view of the new R62, was not prepared to do so for new applications.

10. As for the alleged offer of a “grace period”, EMB explained that it was only an exploratory proposal. This Office accepted EMB’s explanation as reasonable. There was no evidence to support the allegation of abuse of power by the ED officer concerned.

11. On balance, this complaint point was partially substantiated.

Complaint (b)

12. EMB explained that the vetting of applications to register as Permitted Teachers involved verification of qualifications with the Civil Service Bureau and, depending on the origin of documents presented, the Bureau might need to consult the Hong Kong Council for Academic Accreditation. Such cases would, therefore, take longer to process.

13. Of the six cases quoted by the complainant, three required clarifications with the Council. There were two instances of minor slippage but this Office found no undue delay by ED / EMB in processing the applications. This Office accepted EMB’s explanation that the minor slippage had been caused by considerable increase in caseload and reduction in manpower.

14. This complaint point was, therefore, unsubstantiated.

Summaries of Selected Cases Concluded by Full Investigation

Complaint (c)

15. This Office noted that in the circular requesting school supervisors to provide information on their schools in accordance with Regulation 94 and section 39 of the Education Ordinance, ED had asked supervisors to sign on the return signifying their understanding of the uploading of information. This should adequately discharge ED of any intention to deceive school supervisors.

16. In this light, this complaint point was unsubstantiated.

Complaint (d)

17. Section 3 of the Education Ordinance defines a school as "an institution ...which provides for 20 or more persons during any one day or 8 or more persons at any one time, any nursery, kindergarten, primary, secondary or post secondary education...". In response to two complaints received in June and August 2002, one anonymous and the other from a member of the public, against a school operating without registration, the ED Central Compliance Team conducted site visits and found only three children on the premises in the first case and none in the second. ED could not, therefore, establish that a school was in operation.

18. As ED had followed up the two complaints, this complaint point was unsubstantiated.

Complaint (e)

19. EMB admitted that private schools had not been consulted prior to the introduction of Education (Amendment) Bill 2000 into the Legislative Council but it did consult the Board of Education and the Panel of Education of the Legislative Council. Furthermore, when the Bill was introduced, there was no organisation representing tutorial schools and it was not possible to consult them.

20. While this Office accepted there was practical difficulty for ED to consult each and every tutorial school, we considered that as an open and responsible department, ED could have consulted members in the relevant sector prior to finalising the Bill.

21. In this light, this complaint point was partially substantiated.

Conclusion and Recommendations

22. Overall, this complaint was partially substantiated.

23. EMB accepted our recommendations as follows –

(a) to make it clear and explicit to schools that the uploading of school information onto the EMB website is not mandatory and subject to their consent; and

(b) to ensure that affected parties / organisations are adequately consulted on any major legislative or policy change.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

FOOD AND ENVIRONMENTAL HYGIENE DEPARTMENT (FEHD)

Case No. OMB 2003/0567

FEHD – staff attitude – (a) poor attitude of staff in carrying out his duties; and (b) improper handling of a staff complaint – partially substantiated

The complainant alleged that he had witnessed the rude manners of a member of FEHD staff towards a hawker in his enforcement action against road obstruction. When he tried to reason with that staff, he was also treated with rudeness and arrogance. That staff said if the complainant was dissatisfied, he could lodge a complaint. When the complainant telephoned FEHD Complaints Section, a female staff answered his call and asked him to describe the sequence of events and the behaviour of the staff. She added that the definition of impoliteness was open to interpretation. If he could not provide any substantive information, she would only note the complaint and not follow up. The complainant considered the enforcement staff's attitude poor and the female staff's improper as she had failed to ask for the number of the staff concerned and left it to the complainant to offer to provide the staff number. He, therefore, lodged a complaint with this Office.

Complaint (a)

2. On the complainant's claim that the FEHD staff's attitude was poor, there was no independent third-party witness. This Office was, therefore, unable to judge the manners of the staff at the material time. Hence, complaint (a) was unsubstantiated.

申訴專員 The Ombudsman

Complaint (b)

3. This Office noted that FEHD had issued two administrative circulars to staff : “Handling of Operations-related Complaints” and “Handling of Staff-related Complaints” instructing them on how to properly handle and follow up complaints. However, the two circulars failed to guide staff on how to handle a complaint from the public in the course of their duties.

4. As regards the complainant’s allegation that he had telephoned the Department’s Complaints Section that day, FEHD said that the number was that of a newspaper. The Department had no record of any such complaint, nor did any female staff answer any complaint by telephone. During our investigation, the complainant provided us with a statement of his mobile phone calls. It proved that the complainant had called on the morning in question and, on our inquiry, FEHD confirmed that the number dialed did belong to the Radio Communication Control Room of its Hawker Control Team Office. However, the Department still insisted that there was no record of that call while the three female staff on duty that day could not recall receiving the complainant’s telephone complaint.

5. This Office believed the complainant had indeed telephoned the Department and a female staff had answered his call. However, she failed to record the call or report to her supervisor for follow-up action. FEHD had not provided appropriate guidelines for staff to follow up properly complaints arising in the course of their execution of duties. In this light, complaint (b) was substantiated.

6. Overall, The Ombudsman considered the complaint partially substantiated.

Conclusion

7. The Ombudsman made the following recommendations to FEHD –

(a) to revise and supplement the two circulars with guidelines for staff on how to handle complaints properly when confronted with complaints in the execution of their duties. The management should adopt effective measures to ensure that all telephone calls from the public would be properly recorded and processed; and

(b) to take effective measures for strict compliance of guidelines by frontline staff. They must not choose to omit recording complaints in order to ensure that all complaints would be actively pursued by the Department.

8. FEHD undertook to implement these recommendations as soon as possible.

This case highlights The Ombudsman’s role in ensuring that the public sector continues to improve quality and efficiency and that wrongs are righted.

Summaries of Selected Cases Concluded by Full Investigation

FOOD AND ENVIRONMENTAL HYGIENE DEPARTMENT (FEHD)

Case No. OMB 2003/0664

FEHD – transfer of licence – (a) failing to notify the complainant at once after the application for transfer of food business licence was unilaterally withdrawn by the licensee; and (b) failing to handle her application documents properly so that her personal data might be divulged – substantiated

The complainant and the holder of a food business licence (licensee) applied together at an FEHD office for transfer of the licence. Health Inspector A (Inspector A) indicated that he would pass the application documents to Health Inspector B (Inspector B) upon his return from vacation leave, because the latter was responsible for the district where the food business was located. He also told the complainant to call Inspector B one month later to check progress of the application.

2. The licensee returned an hour later to cancel the application for licence transfer. Inspector A then tore up the documents, including the copies of identity cards, and threw them into his waste paper bin. A month or so later, the complainant's brother called to enquire about progress, only to learn that the application had been withdrawn. The complainant felt aggrieved and complained to Inspector A's supervisor. The supervisor apologised and added that with the documents destroyed, there was little chance of her personal data being divulged.

Complaint (a)

3. Inspector A did not follow departmental instructions to require the licensee to submit his withdrawal request in writing. Nor did he confirm this request with the complainant. As regards FEHD, before this incident, it only required the party requesting changes to write to the Department and the other party concerned. It did not instruct FEHD staff to ensure that the other party was made aware of the changes. This Office considered that as the application for transfer had been signed and submitted jointly by both parties, FEHD should ensure that the other party was also notified of any significant change (such as withdrawal of application). Thus, both FEHD and Inspector A should be held responsible.

4. This complaint point was substantiated.

Complaint (b)

5. FEHD indicated that staff should treat copies of identity cards as confidential documents in accordance with the Compliance Guide issued by the Office of the Privacy Commissioner for Personal Data (PCO). However, the FEHD Administrative Circular had no instruction on following the Compliance Guide issued by PCO or details about proper handling (e.g. retention and disposal) of documents containing personal data.

6. As Inspector A had simply torn up the application documents and casually thrown them into his waste paper bin, the complainant's concern about possible leak of her personal data was not unfounded. We did not accept FEHD's argument that Inspector A was inexperienced : he had been a Health Inspector for almost three years.

7. This complaint point was, therefore, substantiated.

Other Observations

8. FEHD's internal guidelines stated that for a straightforward application, notification of result should be issued within ten working days from receipt of application. Inspector A was overly cautious in advising that it would take one month to process the application. This was not in accordance with FEHD guidelines.

9. FEHD's Performance Pledge booklet did not cover application for licence transfer, so applicants had no idea how long the process of application would take.

Conclusion

10. Overall, the complaint was substantiated.

Comments from FEHD and Staff Concerned

11. FEHD had taken disciplinary action against Inspector A and issued new guidelines to remind staff to inform the other party when one party requested withdrawal of application for transfer. They should also file application documents properly and not destroy them without proper authorisation.

12. Inspector A admitted that he was at fault, but argued that the case was unfair to him as FEHD had not issued any specific instructions on how to process unilateral withdrawal of application for transfer of licence or how to handle documents containing personal data.

Moreover, it was stated in the application form that the party requesting any change must notify the other party involved. In this light, neither FEHD nor its staff should be responsible for notifying the complainant.

13. Both FEHD and Inspector A held that the processing time of one month as mentioned by Inspector A actually included the time for other administrative formalities after issue of the letter of approval. Inspector A was, therefore, not overly cautious.

Concluding Remarks and Recommendations

14. This Office considered that whilst Government departments could not formulate operational procedures to cover every possible scenario, staff should use their own judgement or consult their supervisors in special circumstances. In this case, when the licensee withdrew his application just one hour later and the other party was not present, the staff should have been more alert and handled the case with caution.

15. In principle, the new licensee should be able to start his business on receipt of the letter of approval of licence transfer. FEHD and Inspector A should not have taken into account the time for completing other administrative formalities.

16. Inspector A also argued that The Ombudsman should not pursue such a trivial complaint as possible leak of personal data. However, improper handling of documents resulting in leakage of such data could be an offence. This Office did not see this as a "trivial" matter.

17. The Ombudsman, therefore, maintained that the complaint was substantiated.

18. FEHD has apologised to the complainant in writing. It had agreed to incorporate new guidelines into its Operational Manual for Hygiene Services, add detailed instructions to its Administrative Circular on proper handling of documents containing personal data and include in its Performance Pledge booklet a performance pledge on handling applications for transfer of food business licences.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency and that wrongs are righted.

Annex 12

Summaries of Selected Cases Concluded by Full Investigation

GOVERNMENT PROPERTY AGENCY (GPA)

Case No. OMB 2002/3014

GPA – complaint handling – failing to secure the complainant's consent before referring his complaint to another party – substantiated

The complainant resided in a GPA-managed Disciplined Services Quarters, where there were four residents' associations set up respectively by four disciplined services. He alleged that a resident, assisted by the wife of the chairman (the Chairman) of one of the residents' associations, distributed in the quarters photocopies of newspaper cuttings that might be defamatory to him.

2. Consequently, he lodged a written complaint with GPA and requested that his letter be referred to the Quarters Team of the disciplined service concerned. GPA, besides complying with his request, copied the letter with his personal data to the Chairman. The complainant was dissatisfied that GPA should, without his consent, have referred his complaint to the husband of one of the persons involved.

3. GPA explained that the incident was basically a personal dispute. GPA thus hoped that the Chairman could help to mediate and resolve matters without too much fuss. Furthermore, the incident was already known to everyone there and the key target of complaint was a resident, not being the wife of the Chairman. GPA, therefore, sent a copy of the complaint to the Chairman without notifying the complainant or seeking his prior approval.

4. GPA added that as the incident involved the wife of the Chairman, the Quarters Team would have to contact the Chairman for information in the course of investigation. He would, therefore, sooner or later know about the complaint and guess the identity of the complainant. Besides, the complainant was himself the chairman of a residents' association set up by another disciplined service, his personal data were no secret to the Chairman.

5. Upon review, GPA admitted that it would have been much better had the complainant's consent been obtained before his complaint was copied to the Chairman.

6. This Office was of the view that in referring a complaint, GPA should have considered the rights and interests of the complainant and sought his prior approval. As the complaint involved the wife of the Chairman, there could be a conflict of interests to get him to mediate. It could even invite questions as to his fairness in handling the matter.

7. GPA was careless in copying the complaint with the complainant's personal data without his consent. It had failed to exercise due caution nor done its duty to protect the identity of the complainant.

8. The Ombudsman considered this complaint substantiated.

9. GPA had accepted the following recommendations by The Ombudsman –

(a) send a written apology to the complainant for its failure to obtain his consent before referring his complaint;

(b) formulate clear guidelines for staff to get written approval from the complainant before referring a complaint; and

(c) enhance the respect of its staff towards personal data and instruct them to follow the rules and guidelines strictly in handling referrals involving personal data.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency and that wrongs are righted.

HOME AFFAIRS DEPARTMENT (HAD)

Case No. OMB 2002/4452
OMB 2002/4473

HAD – ownership records – maladministration in assisting an owner to obtain the ownership records of an estate free of charge – substantiated

The complainants were the owners of units in a residential estate. In November 2002, they learned that HAD had assisted another owner to obtain the ownership records of the estate free of charge for the purpose of forming an owners' corporation (OC). However, HAD did not require verification of documents to prove that the owner concerned had the requisite support from other owners for forming an OC. On the other hand, for any other owner subsequently making a similar request, HAD would verify the information submitted before rendering assistance.

2. HAD explained that, according to internal guidelines, it would issue a certificate to the first owner making an application, to facilitate his obtaining the ownership records from the Land Registry free of charge, provided that he had secured 5% of the owners' shares in support. The owner had to sign an undertaking that the information would be used for OC

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formation only, that he would observe the Personal Data (Privacy) Ordinance and that he would surrender those records to HAD upon request. HAD issued the certificate to the above owner upon his compliance with those guidelines.

3. However, if any other owner subsequently also secured 5% of the owners' shares in support of OC formation and approached HAD, the Department would then ask that owner to give a public notice of meeting by publication in local newspapers before offering him assistance to get the ownership records from the first owner.

4. According to the Building Management Ordinance, before forming an OC, an owners' meeting must be convened to appoint a management committee. An owners' meeting requires owners holding not less than 5% of the shares to act as "convenor". This requirement differs from that in HAD's internal guidelines, which required only the "support" of owners of not less than 5% of the shares. In this case, before issuing the certificate to the first owner, HAD had not checked whether there were indeed owners of not less than 5% of the shares willing to act as "convenor".

5. HAD was wrong to issue the certificate without verifying whether the first owner had obtained the number of shares claimed, and whether his supporters were really owners in the estate. HAD was also improper and unfair to treat any subsequent owner differently applying for free use of the records.

Conclusion and Recommendations

6. The Ombudsman considered this complaint substantiated.

7. This Office recommended that HAD –

(a) revise its internal guidelines on handling applications for the certificate to conform with the requirements of the Building Management Ordinance; and

(b) stipulate in the internal guidelines that staff must verify the information provided by applicants for the certificate.

8. HAD accepted our comments and recommendations.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.

HOME AFFAIRS DEPARTMENT (HAD)

Case No. OMB 2003/1782

HAD – voter registration – entering the complainant's name in the voter register of another village, so that he was disqualified from standing for the Village Representative election – substantiated

The complainant, an indigenous inhabitant of Village A, submitted a Village Representative (VR) election nomination form to a HAD District Office (DO) to stand for the Indigenous Village Representative election of his own village. However, DO rejected his nomination because his name was not in the voter register of Village A. The complainant then discovered, and complained, that HAD had entered his name in the voter register of Village B, thus disqualifying him from standing for election in Village A.

2. According to HAD records, the complainant had declared himself an indigenous inhabitant of Village B in his Application for Voter Registration. DO thus entered the relevant Village and Rural Committee codes in the form and HAD, his name in the Village B voter register.

3. The complainant subsequently requested HAD to amend the voter register to reinstate his eligibility for election in Village A. On Department of Justice (D of J) advice, HAD rejected his request as the problem was not due to clerical or printing errors.

4. This Office noticed that, while the complainant was at fault in writing down Village B as his address, he had on the other hand stated that his village was under the Rural Committee of Village A. Had DO staff been more alert and checked the details, this incident could have been avoided.

5. HAD argued that the final interpretation of the law should be left to a judge and D of J had advised against amending the voter register. This Office considered that a legal advice from D of J was not equivalent to a judge's interpretation of the law. The provisions of the Village Representative Election Ordinance would allow for rectification of incorrect name or address or other personal particulars. There was, therefore, inadequate basis for HAD's refusal to amend the final register to reinstate the complainant's eligibility for election.

Conclusion and Recommendations

6. In view of the above, this complaint was substantiated.

7. The Ombudsman recommended that HAD apologise to the complainant again in writing and instructed staff to be more careful in processing election-related documents. The Department accepted both recommendations.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

HOSPITAL AUTHORITY (HA)

Case No. OMB 2003/0080

HA – liver transplant – maladministration of a hospital under HA, such that the complainant lost his chance of a liver transplant – substantiated other than alleged

The complainant, a liver disease patient, was waitlisted for liver transplant at a hospital under HA for treatment. One day in September 2002, a doctor at the hospital telephoned the complainant at about 5 p.m., telling him to go to the hospital as soon as possible for operation because they had a healthy liver for transplant. The complainant went to the hospital at once and underwent a series of pre-operation tests. He was then kept waiting until after 10 p.m., only to be told that the operation had been cancelled due to certain resource problems at the hospital. Meanwhile, the liver graft had been sent to another hospital.

2. The complainant considered it extremely unfair that maladministration on the part of the hospital had deprived him of his chance for liver transplant.

Information Provided by HA and the Staff Concerned

3. HA explained that, as there was no telling when a liver might be available for transplant, the hospital could not possibly have all the necessary resources for the operation (e.g. surgery team, anaesthetists, perfusionists, operating theatre and intensive care unit) on standby at all times. Normally, when a liver became available, the hospital would initially identify a patient on the waiting list and notify him to come for pre-operation tests. Meanwhile, the Chief of Service in Surgery (C of S) would carry out a "comprehensive assessment" to determine whether a transplant could proceed. Due to budget constraints of HA and shortage of perfusionists in the hospital, C of S informed the liver transplant team that his prior approval was required before any transplant could proceed.

4. HA reiterated that potential organ recipient notified by the hospital should not assume that a transplant would automatically proceed before the comprehensive assessment was complete. In principle, only when all the necessary resources were available and the essential hospital services not affected could the operation be performed.

5. In the course of comprehensive assessment, the C of S at the hospital concerned was aware that two core members of the transplant team, including the patient's surgeon in-charge (Surgeon I/C), had not had enough rest after performing two very complicated operations (each taking more than ten hours) two days ago and on that very same day. Moreover, perfusionist support was not adequate that night. To proceed with the transplant would also mean the postponement of several scheduled surgical operations, including three for patients in critical condition. He, therefore, decided at around 7 p.m. that the operation should not proceed and informed the Surgeon I/C of his decision. The latter, however, did not concur with him.

6. Surgeon I/C further commented that while notifying the patient after the "comprehensive assessment" might assure him better of the operation, a liver graft could not be preserved for long and the potential recipient had to fast for at least six hours before the operation. Furthermore, if for some reasons, the patient identified was found unfit for the transplant, another patient would have to be found. Time would then be even tighter for all parties concerned. Hence, it was not improper to notify the patient for admission before the C of S finished his "comprehensive assessment" and gave his approval.

Observations and Opinions

7. Whether the members of the liver transplant team were mentally and physically ready to perform the operation and what kind of personnel would be required to provide technical support involve professional medical judgement and are matters outside the jurisdiction of The Ombudsman. In this light, we would not comment on the different views of Surgeon I/C and C of S on these issues.

8. On procedures, however, due consideration should be given to the actual circumstances in determining when a patient should be notified for admission into hospital. In this case, the points raised by Surgeon I/C (para. 6 above) were not unreasonable. However, while notifying the patient, the staff concerned ought to have alerted him that the transplant might not take place under certain circumstances (such as lack of support personnel) lest the patient be disappointed. We believe that neither Surgeon I/C nor other staff had put this point to the complainant that day.

9. The complainant was not told of C of S' decision not to proceed with the operation until around 10 p.m. that night (i.e. three hours after the decision). This Office noted that the delay was caused by disagreement between C of S and Surgeon I/C. They discussed the issue time and again while the complainant was left waiting for an extra three hours. Notwithstanding the good intention of Surgeon I/C in fighting for a transplant for his patient, the delay showed up a lack of effective mechanism for resolving differences of opinions and for reaching a consensus quickly for the benefit of a patient.

10. Liver transplant is an expensive and complex surgery, not funded by HA in the hospital concerned. Members of the liver transplant team knew that limited resources meant limited technical support, such as perfusionists, for such operations. As a liver transplant had just taken place two days before then, Surgeon I/C should have discussed with C of S the availability of resources beforehand. This would have been much fairer to the complainant and not give him false hopes.

Conclusions and Recommendations

11. Whether the operation should have proceeded or not involved clinical judgement. They were non-administrative matters and this Office was not in a position to comment. However, The Ombudsman considered that there was evidently insufficient coordination over liver transplant services in the hospital concerned and the incident fully exposed the internal conflicts.

12. Overall, this Office concluded that while the complaint point was not substantiated, there was indeed other matters of maladministration on the part of the hospital.

13. As HA had set up new arrangements regarding liver transplant service, The Ombudsman recommended that HA formulate clear guidelines, stating clearly who should make the decision as to whether an operation can proceed and in what circumstances a waitlisted patient should be notified for admission into hospital. HA should also instruct its staff to explain clearly to patients that an operation might not take place in some circumstances in order to avoid misunderstanding and unrealistic expectations.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

Summaries of Selected Cases Concluded by Full Investigation

HOUSING DEPARTMENT (HD)

Case No. OMB 2002/1084

HD – management fund account and management rights – (a) misleading some owners of an estate by stating that the management fund could be split in three months after the formation of their owners' corporation; (b) delaying the splitting of the management fund; (c) disrespecting the owners' corporation by directly sending individual owners two letters regarding estate management rights and management supervision fees; (d) delaying the fitting-out of the new management office; and (e) unnecessarily redefining the agreed boundary without consulting the two owners' corporations – partially substantiated

The complainant was the owners' corporation (OC) of a block in a Home Ownership Scheme (HOS) estate. The block was ready for occupation in 1992 and the other six blocks in the estate earlier, in 1987. The former, therefore, has a separate Deed of Mutual Covenant (DMC) from the latter. Consequently, the estate formed two separate OCs. The complainant came into being in July 1999, while the OC of the other six blocks was formed in June 2001.

2. In the early years, HD acted on behalf of the Hong Kong Housing Authority as the DMC manager of the estate. It kept the income and expenditure of all seven blocks in a single account. Upon formation of the two OCs, HD had to split the management fund between them and prepare for the handover of estate management to the OCs.

Complaint (a)

3. The complainant claimed that a staff member of HD's estate management office had misled some owners at a meeting in March 1999 that the splitting of the management fund would be completed in three months upon formation of their OC, without specifying that this was subject to the remaining six blocks forming their OC. As a result, the complainant made a wrong decision not to take over the management of the block while waiting for the splitting of the management fund.

4. This Office considered that the HD officer concerned had been unduly too optimistic about the timing of the splitting of the management fund. She had hastily answered the question put to her without elaborating any potential problems, thus giving rise to misunderstanding. However, she had no intention to mislead, and she did not cause the complainant to lose the opportunity of taking back the management of the block. This complaint point was, therefore, unsubstantiated.

Complaint (b)

5. Our investigation revealed that the major cause of the problem in splitting the management fund was that HD had kept the income and expenditure of all the blocks in one single account. Before the enactment of the Building Management Ordinance (BMO) in 1993 to encourage owners to form OCs, HD did not envisage the need for splitting the management fund later, so it kept only a single account. Such practice had, however, no legal basis. HD started to draft proposals for splitting the management fund only after the complainant's OC had been formed. The complainant did not accept any of HD's four proposals. It questioned their fairness and requested HD to provide all invoices and receipts for verification.

6. According to the BMO, the DMC manager shall permit any owner to inspect the books or records of account at any reasonable time. The complainant was, therefore, exercising its statutory right to inspect invoices and receipts for verification. Between February 2000, when the complainant raised the request, and March 2002, when it complained to this Office, HD had failed to provide the requested documents. In late 2001, after HD had sorted out the relevant records, it contracted out the splitting of the management fund to an independent accountant but did not give photocopies of the documents to the complainant. It further declined the complainant's request for photocopies on the ground that such action would hinder the work of the accountant.

7. As HD did not provide the invoices and receipts to the complainant and delayed responding to the complainant's legitimate request, it had failed in its duty as the DMC manager. This complaint point was, therefore, substantiated.

Complaint (c)

8. HD sent letters directly to individual owners in September 2000 and February 2001, to notify them of the Housing Authority's approval of the "Formation of Owners' Corporation – Five Year Rolling Plan" and its major implications. The letters urged the owners to incorporate themselves and take back the management of their block as soon as possible. They were standard letters that HD issued to all HOS flat owners. The complainant had taken the HD's action to be an act of disrespect. HD nevertheless apologised to the complainant for the misunderstanding caused. We accepted HD's explanation. This complaint point was, therefore, unsubstantiated.

Complaint (d)

9. The fitting-out of the new management office was delayed because the complainant had changed the design and floor plan several times. This complaint point was unsubstantiated.

Complaint (e)

10. Actually, HD did not redefine the boundary separating the two OCs. Its surveyor just enhanced the accuracy of the boundary on the survey plan to prevent any future disputes over the OCs' management and maintenance responsibilities. This complaint point was unsubstantiated.

Conclusion and Recommendations

11. Overall, the complaint was partially substantiated.

12. This Office recommended that HD –

(a) send a written apology to the complainant for delaying the provision of invoices and receipts;

(b) examine all other cases of HOS estates with more than one DMC and income and expenditure in a single account, and take remedial actions to split the account;

(c) formulate guidelines to ensure that frontline staff understand the procedures for forming OCs;

(d) seek help from professional staff of the Home Affairs Department (HAD) where necessary to provide services to flat owners; and

(e) make use of HAD's publications to introduce systematically to HOS flat owners the relevant legislation, the procedures for OC formation and taking over estate management.

13. HD has accepted and fully implemented the above recommendations.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.

Annex 12

Summaries of Selected Cases Concluded by Full Investigation

HOUSING DEPARTMENT (HD)

Case No. OMB 2002/4610

HD – estate management – ineffective supervision of the property services company at a public housing estate, resulting in unfair allocation of public venues – substantiated

A community organisation (Organisation A) complained against HD for ineffective supervision of the property services company (PSC) at a public housing estate. As a result, the PSC unfairly allowed two local personalities to use several public venues in the estate for a prolonged period, thereby depriving other organisations of the use of those venues.

2. The PSC was appointed by HD in mid-2002 to manage the estate and one of its duties was to handle bookings of all open areas. In July 2002, two local personalities applied to the PSC for the use of five of the nine venues in the estate for conducting a residents' opinion survey over seven months. The PSC approved the application without consultation with HD.

3. Organisation A therefore complained to HD and the PSC. The PSC then advised the organisation to use other venues in the estate.

4. HD subsequently asked the PSC to draw up guidance notes on the booking of venues for distribution to local organisations. Henceforth, the PSC would only process applications submitted on or before a fixed day each month for use of venues in the following month.

5. Meanwhile, HD reached a consensus with the two local personalities that, if any other organisations applied for use of the venues in question, it would be settled by negotiation or drawing lots, subject to the conditions in the guidance notes being met.

6. HD observed that the PSC had not handled the case properly. It had not fully considered the needs of other people nor consulted HD before allowing the two local personalities to block-book more than half of the venues for seven consecutive months. We agreed with HD on this point.

7. HD maintained that it had never drawn up any guidelines governing the assessment of such booking applications. It regarded venue booking as part of the "daily routine" of estate management. PSCs should possess adequate general knowledge on estate management to ensure reasonable allocation of venues without HD's prior instructions. If HD issued guidelines on such matters, it would only hamper the full play of management expertise by the PSC.

8. This Office did not accept HD's explanation. Although estate management has been contracted out, HD still has the overall responsibility for ensuring that public resources are fairly and reasonably used. This Office considered that, for good management, HD should have formulated guidelines in advance for PSCs to process bookings of venue properly. In this respect, HD had failed to fulfill its supervisory function.

9. The Ombudsman, therefore, considered this complaint substantiated.

10. Having learned a lesson from this incident, HD issued guidelines to all PSCs, specifying the criteria and procedures for processing applications for venue booking.

11. This Office recommended that HD should regularly inspect all PSCs to ensure the implementation of such criteria and procedures. Furthermore, HD should apologise to the complainant.

12. HD accepted our recommendations.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.

HOUSING DEPARTMENT (HD)

Case No. OMB 2003/1786

HD – time limit for prosecution – delay in processing a report on the use of a forged document to apply for public housing, resulting in the case being time-barred from prosecution – substantiated

The complainant reported to HD in June 2001 that an ex-employee had forged an employer's certificate to apply for public housing. In the event, delay by HD staff caused the case to be time-barred from prosecution.

2. According to the Housing Ordinance, proceedings against an offence of giving a false statement when applying for a public housing may be brought at any time within six years after commission of the offence or within one year after discovery thereof by an authorised officer, whichever period expires first.

3. Upon receipt of a report of such an offence, the Housing Manager / Prosecutions of HD would first confirm the discovery date of the offence and determine the statutory time-barred date (STBD) as stipulated in the Ordinance. An Assistant Housing Manager /

Prosecutions would check the STBD and then pass the case to a Housing Officer for processing chronologically in accordance with STBDs. The Housing Officer should start screening cases at least four months before their STBDs, completing scrutiny with recommendations preferably one month before. This would allow time for senior officers to decide whether or not to prosecute.

4. In this particular case, HD's Applications Section received the report on forged document on 13 June 2001. However, the Assistant Housing Manager, who happened to be also Acting Housing Manager / Prosecutions, mistook 17 July 2001 as the discovery date. The STBD thus fell on 16 July 2002 instead of 12 June 2002. It was not checked by another officer.

5. When the Housing Officer started processing the case on 25 March 2002, it was just under four months from the July STBD. She reported the case to her new supervisor on 11 July 2002 and recommended prosecution. It was just five days before the STBD, not the preferred minimum of one month.

6. Her supervisor then found that the STBD should actually fall on 12 June 2002. In this light, prosecution was time-barred.

Conclusion and Recommendations

7. HD's mistake was due to –

(a) wrong setting of the STBD;

(b) failure in checking the STBD;

(c) late submission of the case for prosecution; and

(d) inadequacy in monitoring of cases for timely submission.

8. This Office considered the complaint substantiated.

9. The Ombudsman recommended that HD –

(a) issue an apology to the complainant;

(b) consider action on the officers concerned;

(c) review procedures for timely processing of cases;

(d) give firm and clear guidelines to staff; and

(e) review all time-barred cases to identify any officer accountable and other systemic improvement measures necessary.

10. HD accepted our findings and recommendations.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency.

HOUSING DEPARTMENT (HD)

Case Nos. OMB 2003/1989
OMB 2003/3238

HD – water seepage – (a) delay in resolving ceiling seepage problem – substantiated; and (b) unfair treatment to the tenant whose unit was alleged to have caused the seepage – unsubstantiated

Two public housing tenants complained separately against HD for mishandling the same case of ceiling seepage. The tenant downstairs first reported to HD on her ceiling seepage in 1996 and then in 1999. Although HD had carried out repairs many times in the unit, the problem persisted. HD staff thus considered that the seepage probably originated from the unit upstairs.

2. To arrange for inspection and repairs in the unit upstairs, HD had time and again telephoned and written to the tenant upstairs and sent staff to visit the unit but all in vain. The tenant upstairs evaded contact with HD staff and used various excuses to deny them entry.

3. The Tenancy Agreement stated that a tenant should permit HD at all reasonable times to enter and do any repairs for which the Department as Landlord was liable. However, the tenant upstairs took no notice of HD's advice and warnings.

4. On 1 August 2003, HD implemented the Marking Scheme for Tenancy Enforcement (Marking Scheme) whereby tenants who "deny HD staff or staff representing the HD entry for repairs responsible by the HD" should be allotted seven points as warning. HD invoked this rule and urged the tenant upstairs to cooperate. As she repeatedly ignored HD's warning letters, the Department allotted her a total of 14 points. Under the Marking Scheme, a tenancy would be terminated when allotted 16 points.

Complaint by Tenant Downstairs

5. During the four years handling the case, HD had issued a total of 61 letters (including eight warning letters) to the tenant upstairs. However, the letters were repetitive in contents, reiterating only the terms of tenancy without indicating any substantive action to be taken. They had no deterrent effect on the tenant upstairs. HD had also failed to exercise its authority under the Tenancy Agreement to secure cooperation from the tenant upstairs and had not actively considered issuing a Notice to Quit in accordance with the terms of tenancy. Consequently, the tenant downstairs had to suffer the nuisance from the seepage year after year.

6. The Ombudsman, therefore, considered the complaint by the tenant downstairs substantiated.

Complaint by Tenant Upstairs

7. The tenant upstairs claimed to have allowed HD technicians to carry out works in her unit "many times". However, this Office noted that HD had only carried out a seepage test in the unit and repaired the drain outlet of the toilet. While HD sought the tenant's cooperation time and again, HD staff were repeatedly denied access on various excuses. It was obvious that the tenant had no intention whatsoever to cooperate.

8. HD was willing to repair any damage to the bathtub caused by previous works and arrange a transfer of unit for health reasons. Nevertheless, the tenant refused to produce a medical certificate. This Office considered that the tenant had no grounds for constantly refusing to cooperate with the Department.

9. The tenant upstairs had clearly not complied with the Tenancy Agreement. As for HD allotting points under the Marking Scheme as warning, it was only the tenant's own doing.

10. In view of the above, The Ombudsman considered the complaint by the tenant upstairs unsubstantiated.

Recommendations

11. HD accepted the following recommendations by The Ombudsman –

(a) to send a written apology to the tenant downstairs;

(b) to take decisive actions (e.g. strict enforcement of the Marking Scheme or termination of tenancy) to solve the problem effectively if the tenant upstairs continued to be uncooperative; and

(c) to expeditiously arrange transfer for the tenant downstairs if desired.

These two cases highlight The Ombudsman's role in ensuring that wrongs are righted and facts are pointed out when public officers are unjustly accused.

HOUSING DEPARTMENT (HD) AND ARCHITECTURAL SERVICES DEPARTMENT (Arch SD)

Case Nos. OMB 2002/3628
OMB 2003/0649
OMB 2003/0650

HD - maintenance responsibility – (a) shirking responsibility for coping with the back-flow of sewage into the lift pit of a school and failing to follow up the blockage of public drainage to prevent recurrence of such sewage back-flow – unsubstantiated

Arch SD – emergency repairs – (b) failing to provide appropriate services to the school regarding the sewage back-flow incidents – substantiated

The complainant, an aided school, was situated within a Home Ownership Scheme (HOS) estate, the Owners' Corporation of which had yet to be formed. HD, as the agent of the Hong Kong Housing Authority (HA) to execute the Deed of Mutual Covenant, was responsible for supervising the estate management company's day-to-day performance. According to the contract, the management company was required to inspect the public drainage in the estate once a month and to carry out dredging or maintenance as necessary. However, the responsibility of maintaining the school premises had been entrusted by the Education and Manpower Bureau (EMB) to Arch SD. In accordance with EMB's guidelines, for emergency repairs, the school should fax an application to Arch SD direct with a copy to EMB. Upon receipt of such application, Arch SD staff would visit the school for investigation. Should the repair cost less than $3,000, the school would have to arrange and pay for the works. Nevertheless, Arch SD was responsible for providing professional assessment and technical advice.

Annex 12

Summaries of Selected Cases Concluded by Full Investigation

Complaint (a)

2. On 19 March 2002, back-flow of sewage into the school's lift pit occurred for the first time and caused damage to the lift. This was due to blockage of a public drain in the estate. The school notified Arch SD. Later, on learning that the drain was under HD management, the school sought compensation from HD for repair of the lift. HD immediately directed the management company to check the drain and to refer the school's claim to HA's insurance company. In October 2002, the notary public appointed by the insurance company explained to the school that since the blockage had been caused by reckless disposal of construction waste by tenants or workers, the insurance company would not pay for the repair. Nevertheless, to prevent recurrence, HD instructed the management company to step up inspection of the public drainage to twice a month and to post notices in the building lobbies and distribute leaflets to residents on the proper use of drains.

3. On 27 and 29 January 2003, similar incidents occurred in the school, which notified Arch SD and HD immediately. The management company promptly arranged dredging and cleaning up. It further issued notices to remind residents to use the drains properly.

4. We found that HD had actively followed up all three incidents of back-flow and had not shirked its responsibility.

5. This complaint point was, therefore, unsubstantiated.

Complaint (b)

6. An Arch SD officer visited the site the next day after the first incident and found the blockage in the public drain had been cleared by the Drainage Services Department. As the trapped effluent had subsided, he closed the case.

7. We found no specific instructions in Arch SD's guidelines or performance pledge to advise its staff on how to handle applications from aided schools for repairs. Though having received the school's application (dated 27 January 2003) on 28 January, Arch SD staff did not go to the school for investigation or seek a better understanding of the situation. When the subject officer received the school's call for help on the morning of 29 January, he still refused to visit the school until urged by HD and his supervisor. This Office considered the officer's service attitude passive and lacking in enthusiasm.

8. The school asked Arch SD several times for advice on a permanent solution to the problem. The Arch SD officer suggested that the school should block the drainage outlet at the bottom of the lift pit. However, he added that he was not sure whether such blockage

would violate any regulations and that it could only be an interim measure. He also refused to carry out the works for the school because it cost less than $3,000. After three months and on HD's recommendation, Arch SD finally agreed to block the outlet in question. This Office considered the "professional advice" given to the school by the Arch SD officer vague and perfunctory.

9. In view of the above, this complaint point was substantiated.

Conclusion

10. Overall, the complaint was partially substantiated.

11. The Ombudsman recommended that –

(a) HD consider adopting more effective measures to inspect the drainage for timely detection of blockage;

(b) HD refer the school's claim to HOS estate owners' public liability insurance company instead of HA's insurer;

(c) Arch SD review and revise its guidelines in order that both its staff and schools would understand better how to provide and obtain the Department's assessment of repair services and professional advice;

(d) Arch SD apologise to the school; and

(e) EMB take part in Arch SD's review of guidelines.

12. The three departments accepted our recommendations for implementation by phases.

This case highlights The Ombudsman's role in ensuring administrative fairness, that the public sector continues to improve quality and efficiency and that wrongs are righted.

Summaries of Selected Cases Concluded by Full Investigation

LANDS DEPARTMENT (Lands D)

Case No. OMB 2002/0935

Lands D – lease modification – allowing a site to be excessively redeveloped due to: (a) misinterpreting the original lease conditions; and (b) adopting without justification a higher plot ratio than allowed under the relevant outline zoning plan and the Mid-Levels Administrative Moratorium – substantiated other than alleged

Restrictions on Redevelopment

The redevelopment potential of the subject site in the Mid-Levels was determined by: (i) the lease; (ii) Building (Planning) Regulations; and (iii) the outline zoning plan (OZP). The Mid-Levels Administrative Moratorium (the Moratorium) is an administrative measure intended to ease traffic congestion in the Mid-Levels by restricting the intensity of building development and redevelopment.

Complaint (a)

2. The subject site was part of a lot which originally contained one main residence and two outhouses. The lot was subsequently divided into two portions sharing a common lease that allowed a total of three houses, each to be not more than 35 feet in height. The owner of each portion took one outhouse and half of the main residence. One of the portions became the subject site.

3. In 1960-61, the owner of the other portion (the adjacent site) redeveloped her half of the main residence and the outhouse into a residential block and a garage with accommodation for drivers.

4. The complainant believed that Lands D had incorrectly and / or improperly determined that the adjacent site had only one house on it, thus allowing **two** houses to be redeveloped on the subject site, with consequent increase in the permitted plot ratio.

5. We found that while Lands D had always tried to abide by the restriction for “three houses” in the lease, it had displayed inconsistency and uncertainty over how to count the number of houses on the adjacent site. This was due to changes and ambiguity in Lands D’s operational definition of “house” and rationalised by the current definition, adopted in October 1999. According to the latter, the adjacent site contained two houses, while in November 1999, Lands D approved a redevelopment proposal for the subject site consisting of only **one** house, up to ten storeys high over carports.

Complaint (b)

6. According to the Building (Planning) Regulations, the plot ratio of the subject site for a building under 15 metres in height is 3.3. The maximum permitted height for a building on the site, as determined by the OZP, is ten storeys above carports or the height of the existing buildings, whichever is the greater. Since the original lease imposed a height limit of 35 feet on any house erected on the subject site, Lands D's approval of a lease modification was necessary to build up to the height allowed under the OZP.

7. Lands D determined the scale of redevelopment permissible on the subject site by way of a "notional scheme" submitted by a developer, i.e. hypothetical designs to determine the extent of (re)development permitted within the limit of the lease before proceeding further with design and submission of building plans. Having obtained approval for the notional scheme, the developer then applied to Lands D for a lease modification to "stretch" the same gross floor area to fit into a high-rise building. In this regard, Lands D treats any storey containing carparking spaces as "carport" and grants exemption for machine rooms, recreational facilities and lobby.

8. While the proposal appeared *prima facie* to represent more intensive redevelopment in contravention of the principle of the Moratorium, Lands D pointed out that the Moratorium was only an administrative measure with no restrictive effect on existing property rights. Such rights were further taken to mean the maximum plot ratio (i.e. 3.3) and gross floor area permitted on the site before redevelopment. "More intensive development" was thus measured against the notional scheme, not any pre-existing building.

Other Observations

9. Having regard to the above, neither complaint point was substantiated. However, our investigation had identified areas of concern in a number of Lands D's procedures and practices constituting maladministration (justifying a future direct investigation) –

(a) the ability to define key terms flexibly such as "house" and "more intensive development" allowed Lands D to determine and shape policy, which we considered inappropriate and inconsistent. Some of such definitions appeared to defy logic and common sense. They gave the impression that Lands D was serving property owners and developers, rather than protecting the interests of the community as a whole; and

(b) there was a lack of consistency and logic in the way Lands D conducted its meetings. Decisions appeared to be arbitrary, while their lack of transparency ran counter to the spirit of open and accountable government.

10. The Ombudsman, therefore, considered the case substantiated other than alleged.

This case highlights The Ombudsman's role in ensuring administrative fairness.

LEGAL AID DEPARTMENT (LAD)

Case No. OMB 2003/1737

LAD – legal aid – (a) delay in registering a charging order nisi and replacing it with a charging order absolute; (b) failing to deliver court documents by other alternatives; and (c) putting incorrect information in the affirmation – partially substantiated

The complainant, representing a deceased Madam A, lodged a complaint against LAD. Allegedly, Madam A had been granted legal aid to enforce a maintenance order. In early May 2002, the judge accepted LAD's application on her behalf and granted a charging order nisi so that she could register a charge against the property of her ex-husband (the respondent) in the Land Registry. However, LAD had been withholding her application for a hearing on replacing the charging order nisi with a charging order absolute.

2. In early May 2003 (i.e. one year later) LAD staff went to the registration office of the Court to enquire and submitted a draft charging order nisi for Court approval. In mid-May, the Court issued a sealed charging order nisi and set down the date of hearing. Meanwhile, LAD staff registered the charging order with the Land Registry and tried to deliver the court documents to the respondent on 19 and 23 May, but to no avail. When the Department learned that Madam A had passed away on 12 May, it stopped further attempts to deliver the documents to the respondent because, without her instructions, LAD could not continue the proceedings.

3. On 31 May 2003, LAD sent the relevant documents to the legal representative of the executor of Madam A's will including an affirmation bearing "2 June" as the date it was filed. The complainant considered this date misleading. In fact, the affirmation had been dated in advance and for filing to the Court that day.

4. As the Court had granted the charging order nisi in May 2002 and LAD did not submit the draft order to the Court for approval until one year later, this Office considered LAD to be at fault in omission or in delay.

5. However, since LAD could no longer represent Madam A, it was appropriate for it not to deliver the Court documents to the respondent. Lastly, it was not improper to date the affirmation in advance as it was scheduled for filing to the Court on 2 June.

6. In conclusion, the complaint point against LAD for omission and delay in processing the application for replacing the charging order was substantiated but the other points were unsubstantiated. Overall, the complaint was partially substantiated.

7. LAD had accepted our recommendations and indicated that with the upgrading and enhancement of its computer system in mid-2003, all draft orders for Court approval had been systematically recorded and would be duly brought up to avoid omission. Meanwhile, LAD had started to revise the details of its existing guidelines to provide more effective instructions to staff in future and ensure that all necessary procedures would be followed properly.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.

LEISURE AND CULTURAL SERVICES DEPARTMENT (LCSD) AND POST OFFICE (PO)

Case Nos. OMB 2002/4088
OMB 2003/0606

LCSD and PO – despatch of notice – (a) delaying despatch of collection notice from a public library – unsubstantiated

LCSD – staff attitude – (b) being impolite in handling enquiry – unsubstantiated

The complainant requested a public library book through the LCSD "Reservation of Library Materials" service but she only received the collection notice in the evening of the collection deadline. She was, therefore, unable to collect the reserved book in time and went to the library for clarification the next day. While the librarian was politely discussing a possible solution with her, a staff member nearby rudely accused the complainant of delaying the collection of the book on purpose and refusing to pay the reservation fee.

Summaries of Selected Cases Concluded by Full Investigation

Complaint (a)

2. On receiving an application for "Reservation of Library Materials", LCSD staff would hold the requested material and send a notice to inform the reader to collect it within a specified period. Before issuing the notice, the staff would impress the postage and date-stamp on the envelope and despatch it to the designated post office on the same day for delivery.

3. The computer records of LCSD and the date-stamp impressed on the notice showed that the Department had despatched it to the designated post office 12 days before the collection deadline.

4. According to PO, the notice was returned for re-delivery one day before the collection deadline. Since there was no indication of the reason for return of the notice, PO could not ascertain why there was delay in delivery.

5. This Office considered complaint (a) unsubstantiated.

Complaint (b)

6. According to the other library staff on duty on the day of the incident, the complainant asked how the matter could be resolved because the notice was late. The staff concerned raised her voice and insisted that the complainant had to pay the fee whether she had picked up her item or not.

7. LCSD's guidelines stipulated that a fee of $2.50 would be charged for the reservation of each item of library material and the fee was payable once the requested item was available for collection. Under special circumstances, including any loss incurred as a result of the negligence of other parties, LCSD staff could consider waiving the fee upon the supervisor's approval in accordance with internal guidelines. In this case, the staff concerned was inflexible and failed to observe that LCSD might exercise discretion to waive the fee. Nevertheless, we believed that she did not intend to be rude to the complainant but was just speaking rather loudly.

8. Complaint (b) was, therefore, unsubstantiated.

9. The Ombudsman recommended that LCSD confirm with readers the accuracy of their mailing addresses. This Office noted that the complainant had praised the duty librarian in her letter for her positive attitude and flexibility in handling the matter. We, therefore, suggested that LCSD should commend that librarian. LCSD accepted and implemented all our recommendations.

Summaries of Selected Cases Concluded by Full Investigation

This case highlights The Ombudsman's role in ensuring bureaucratic constraints do not interfere with administrative fairness and the public sector continues to improve quality and efficiency.

MARINE DEPARTMENT (MD)

Case No. OMB 2003/2451

MD – marine accident – delay in investigation of an accident and perfunctory action – substantiated

The complainant went diving in Hong Kong waters in May 2003. While emerging from the water, she was hit by a speedboat. She was taken to hospital by friends, was consequently hospitalised for over 40 days and went through two orthopaedic surgeries. After analysing the relevant facts, a Marine Office (MO) recommended not to prosecute the master of the speedboat for insufficient evidence.

2. The file was then forwarded to the Marine Accident Investigation Section (MAI) of MD for further analysis and assessment. Nevertheless, MAI neither recorded receipt of the file nor passed it to an investigation officer for action. When the complainant called to enquire about her case in August, MAI responded that it had never received the file and was not aware of her accident. The complainant thus wrote to MD that day to complain about the incompetence and attitude of its staff. MAI apologised in its reply for the mistake in saying that it had never received the file and indicated that it supported MO's recommendation not to prosecute. Aggrieved, the complainant wrote to MD again to complain. However, the Department only reiterated the reasons for its investigation result.

3. In the guidelines issued by MD to frontline teams, marine accidents were categorised into "major accidents" and "non-major accidents". Accidents in the former category would be referred to MAI for immediate action and the latter taken up by a frontline team to assess their causes. However, the guidelines issued to MAI grouped marine accidents into four categories: namely, "very serious accidents", "serious accidents", "less serious accidents" and "other accidents". The first three categories were within MAI's purview for investigation.

4. MD admitted that its frontline teams in general were not conversant with the criteria set out in the guidelines regarding the definition of a "serious injury" (i.e. the victim suffering at least 72 hours of incapacitation within seven days after sustaining an injury). In this incident,

the MO officer had failed to look personally into the injury of the complainant. He concluded that she had not sustained a "serious injury" solely on information given by her friend. As a result, he did not classify the accident as "major". In fact, the complainant's injury should have been considered "serious". MO ought to have passed her case to MAI at once for action as a "major accident".

5. MD further explained that the workload of MAI had been particularly heavy during that period, so cases of a "less serious nature" had been put aside. This resulted in the file not being passed to an investigation officer.

Conclusion and Recommendations

6. We considered the accident to have been classified incorrectly by MO because of inadequate understanding of the definition of "serious injury" and because MD had not provided frontline staff with sufficient details. Consequently, they had to rely on their own subjective judgment in determining whether an accident was "major". Moreover, MD had issued different guidelines to frontline teams and to MAI. This would lead to different interpretation as to the seriousness of an accident and hence different treatment of a case. The Department also had not given staff any instructions on the confirmation and recording of injuries. No space was provided in the "Report of Marine Accident" form for a victim's account of his injury. As for heavy workload, MD could have redeployed staff instead of putting files aside unattended.

7. In view of the above, this complaint was substantiated.

8. The Ombudsman recommended that MD –

(a) send a written apology to the complainant;

(b) review its guidelines on classifying the seriousness of injuries and accidents;

(c) give staff clearer instructions on the confirmation and recording of injuries;

(d) add a new "injury report" section in the form; and

(e) take measures to ensure files received are properly dated and recorded by MAI, and passed to investigation officers quickly for action.

9. MD accepted all our recommendations and undertook to implement them by phases.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency and that wrongs are righted.

Summaries of Selected Cases Concluded by Full Investigation

SOCIAL WELFARE DEPARTMENT (SWD)

Case No. OMB 2002/4371

SWD – handling of offence reports – (a) evasive attitude of staff in handling the complainants' report on suspected fraud in Comprehensive Social Security Assistance claims; and (b) divulging to the suspected offender that the complainants had reported the case to the Department – unsubstantiated

The complainants, a married couple, had leased their flat to Mr. A. In December 2002, they found a letter sent by SWD Social Security Field Unit (SSFU) to their flat about Comprehensive Social Security Assistance (CSSA). However, the addressee Mr. B was not their tenant. They called the SSFU and an officer there confirmed that the mailing address was correct. Suspecting that Mr. B might have used the address to make fraudulent claims for CSSA, the complainants followed the SSFU officer's suggestion and called the special hotline (hotline) for the SWD Fraud Investigation Team (FIT).

2. The hotline operator allegedly did not take down details of the complainants' report, and only advised them to report in person, with documents such as the tenancy agreement, to the SSFU. Next morning, they went to the SSFU, but the officer was evasive and told them to call the hotline directly since it would take longer to refer their report to FIT. Later, the officer's supervisor showed them the tenancy agreements and rental receipts submitted by Mr. A and Mr. B, which caused the complainants to suspect that they were both making fraudulent claims for CSSA. However, the supervisor also suggested that they report to FIT directly if they wanted prompt action.

3. That afternoon and next morning, the complainants received calls from Mr. A and his girl friend, telling them to mind their own business. The complainants, therefore, suspected that SWD staff had disclosed to Mr. A their reporting the case to the Department.

Complaint (a)

4. The SSFU officer and her supervisor denied that they had been evasive or had suggested the complainants to report to FIT directly. The officer claimed that she had provided the complainants with information about the hotline only because they had asked about the ways of making a report. Her supervisor added that he had in fact promised the complainants to follow up their report.

5. We considered that there was insufficient evidence to prove that the SSFU officer and her supervisor had been evasive in handling the complainants' report. As for the hotline operator, our inquiry confirmed that she had recorded the details reported by the complainants. This complaint point was, therefore, unsubstantiated.

Complaint (b)

6. All SSFU and hotline staff concerned denied contact with Mr. A on those two days. The SSFU officer further stated that she had not entered the details provided by the complainants into the CSSA computer system until a few days later, so it was not possible for other SWD staff to access the information before then.

7. SWD had instructed all staff to keep details of reports confidential. For staff members who accessed the computer system, their identity and operation would be recorded. Moreover, the personal data of informants and details of cases were kept in separate files by FIT.

8. As we could not tell how Mr. A had learned of the complainants' report to SWD, it would be improper for us to pass judgment.

Conclusion and Recommendations

9. Overall, this complaint was unsubstantiated.

10. SWD did not adopt a "one-stop" approach in receiving reports from the public nor did it instruct staff to explain to the public that repeated reporting through different channels was unnecessary. In this particular case, the SSFU officer had twice given the complainants the hotline number and information on FIT, so that they misunderstood that she was giving them the run-around and was unwilling to take up their case. The case also exposed the lack of mechanism for notification between SSFUs and FIT. Consequently, they would not know whether a report had already been made to the other party or which party should follow up the case. In addition, SSFUs did not have security measures in place, similar to those of FIT, to prevent leakage of informants' personal data.

11. The Ombudsman, in addition to recommendations relating to the "one-stop" approach, suggested that SWD should produce special forms for use in SSFUs for reporting; provide informants with case numbers; consider assigning SSFUs to conduct "preliminary investigation" into all cases in view of their prior knowledge of case background; and set performance pledges for different stages of investigation of reports.

12. SWD accepted most of our recommendations. It has formulated new guidelines for staff, instructing them to explain to informants that there is no need for repeated reporting through different channels. Meanwhile, all SSFUs have adopted security measures, similar to those of FIT, to avoid divulgence of informants' personal data.

This case highlights The Ombudsman's role in pointing out the facts when public officers are unjustly accused, and ensuring that the public sector continues to improve quality and efficiency.

TRANSPORT DEPARTMENT (TD) AND LANDS DEPARTMENT (Lands D)

Case Nos. OMB 2003/2039
OMB 2003/2040

TD and Lands D – public pier – (a) shirking responsibility when handling the complainant's enquiries and failing to give him a reasonable reply; and (b) failing to handle properly the issue of inadequate passenger facilities at a public pier – partially substantiated

The complainant, a ferry passenger, made enquiries to Lands D and TD in June and July 2003 about the ferry operator's unsuccessful application for the lease of a public pier to install passenger facilities. He alleged that the two departments were shirking their responsibility and ignoring the safety of ferry passengers.

Complaint (a)

2. In April 2002, on learning the ferry operator's intention to operate a ferry service using the public pier, TD notified Lands D immediately and requested it to process the operator's application for lease of the pier as soon as possible upon receipt of the application. Subsequent letters urging the operator to submit its application were also copied to Lands D. In December 2002, TD issued a licence to the operator to start the service. The licence stated that the ferry operator could have exclusive use of the pier. Nevertheless, the ferry operator did not apply to Lands D for leasing the pier until March 2003. It applied to Lands D for exclusive use of the pier with a view to installing passenger facilities. In May 2003, Lands D rejected the application on grounds of public interest and land policy. A copy of the rejection letter was sent to TD.

3. When the complainant made his enquiries about the issue, TD and Lands D were arguing over the leasing of the pier. The Lands D officer told the complainant that the Department could not grant the lease of the public pier unless TD gave its approval; whilst the TD officer informed him that TD had written to Lands D stating that TD supported the ferry operator's application. The complainant later repeatedly sought clarifications from the two departments. The Lands D officer said that TD's support of the application was not sufficient for Lands D to grant the lease, but TD could take over the pier and grant the lease directly. However, the TD officer said that TD could not do so.

4. Lands D observed that TD should not have granted exclusive use of the pier to the ferry operator without first consulting Lands D. As TD had already issued the ferry service licence, it should take over the pier and grant the lease directly. TD indicated that since April 2002, as Lands D had not responded on the matter, TD had assumed that Lands D would issue a short-term tenancy to the ferry operator. It was not until August 2003 that TD learned that it was not possible. Because of its jurisdiction, TD could not take over the pier and grant the lease.

5. This Office considered the staff concerned to have expressed only the stance of their own department when answering the complainant's enquiries, without realizing that they were actually responding to the same issue on behalf of Government. It was obvious that the departments lacked communication and coordination. The two officers concerned had failed to give the complainant a consolidated reasonable reply on behalf of Government.

6. Complaint (a) was, therefore, substantiated.

Complaint (b)

7. Like other public piers, the pier in question was already provided with basic facilities and safety features. The Home Affairs Department had not received any complaints about the safety of the pier. It was only out of commercial consideration that the ferry operator wanted to lease the pier for installing additional passenger facilities. It did not necessarily mean that there were inadequate proper facilities at the pier.

8. Complaint (b) was, therefore, unsubstantiated.

Other Areas of Maladministration

9. The problem in this case stemmed from TD's failure to check the land use restrictions of the pier before granting its exclusive use to the ferry operator. This obviously constituted maladministration.

10. Although rejection of the ferry operator's application was in line with the relevant land policy, Lands D had not responded to TD's documents copied to it and failed to remind TD of the land use restrictions of the pier. Furthermore, Lands D rejected the application directly without consulting TD, neglecting that the two departments were working partners. This Office considered Lands D too bureaucratic and inflexible, lacking alertness and a spirit of cooperation.

11. The Lands D officer concerned was also found negligent. Without first obtaining TD's confirmation, he had put forward to the complainant a proposal which TD later found to be not feasible.

Conclusion and Recommendations

12. Overall, this complaint was partially substantiated.

13. The Ombudsman recommended that TD and Lands D issue guidelines to their staff for proper handling of public enquiries involving other departments, in particular that replies should be made only with consensus having been reached with other departments.

14. The Ombudsman also recommended that TD review and revise its guidelines, and strengthen its supervision over, the procedures for issuing ferry service licences. She further recommended that Lands D formulate guidelines for proactive handling of copies of correspondence from other departments and to take effective measures to eliminate bureaucratic practices, to cultivate a positive service culture and promote a team spirit of cooperating with other departments.

15. TD and Lands D had accepted in principle our conclusion, though Lands D considered that its officer had not improperly handled the complainant's enquiries in this case. This Office would monitor the implementation of our recommendations by the two departments.

This case highlights The Ombudsman's role in ensuring that the public sector continues to improve quality and efficiency and that wrongs are righted.

Summaries of Selected Cases Concluded by Full Investigation

WATER SUPPLIES DEPARTMENT (WSD)

Case No. OMB 2003/0641

WSD – water charges – (a) providing the complainant with incorrect inspection findings; and (b) charging excessively high water charges – partially substantiated

The complainant lodged a complaint with WSD's Customer Telephone Enquiry Centre (CTEC) against excessively high water charges and asked for an investigation. After recording the details, CTEC referred the case to the Consumer Accounts Team (CAT) for follow-up action.

Complaint (a)

2. When processing the case, CAT staff misplaced the inspection findings of another account into the complainant's file. Based on those findings, CAT wrote to the complainant that they had found a water pipe in her unit to be illegally connected to a flushing cistern, which had leaked resulting in high water charges. The complainant pointed out that WSD staff had never inspected her unit and the findings were false.

3. According to WSD, it was an oversight of CAT staff. The Department had explained to the complainant over the telephone and sent her a written apology.

4. After reviewing the filing procedures of the Department's site inspection reports and its action on cases recorded by CTEC, this Office found that there were errors in the filing process which constituted maladministration. The Ombudsman considered this complaint point substantiated.

Complaint (b)

5. Regarding the water charges, it was confirmed upon testing that the water meter was working properly. As WSD had based the water consumption recorded in the meter to charge the complainant, it had not acted inappropriately. The Ombudsman, therefore, considered this complaint point unsubstantiated.

Conclusion

6. Overall, The Ombudsman considered this complaint partially substantiated.

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7. To avoid recurrence of such incidents, WSD had instructed its staff concerned to be more careful when handling files and responding to complaints.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.

WATER SUPPLIES DEPARTMENT (WSD)

Case No. OMB 2003/2110

WSD – fire hydrant leakage – failing to take immediate follow-up action – substantiated

The complainant alleged that WSD had failed to take immediate action to repair a leaking fire hydrant despite his complaint thrice.

2. According to WSD, its staff conducted a site inspection after receiving the first complaint. Finding the fire hydrant leaking slightly, they secured the valve to stop it. The complainant later observed that leakage again. He then lodged his complaint twice with WSD's Customer Telephone Enquiry Centre (CTEC). Nevertheless, WSD took no action for more than ten days. Only when the complainant complained to this Office that WSD realised their omission.

3. WSD explained that whenever CTEC received a fault report outside office hours and considered it "serious", it would ask the standby duty staff to take action. However, that evening, the duty supervisor considered fire hydrant leakage a "minor" fault whichcould be dealt with by the regional staff the next day during office hours. The duty supervisor thus sent the complaint to the regional office for its day shift staff, without informing the night shift standby duty staff to monitor. When the day shift staff downloaded the complaint from the computer and noted that it had been received outside office hours, they assumed that the night shift had handled it and therefore took no action.

4. To avoid recurrence, WSD has revised its procedures for handling fault complaints -

(a) all fault reports received by CTEC outside office hours, whether "serious" or "minor", should be faxed to the regional office. Standby duty staff should endeavour to complete the necessary work within their shift. For cases yet to be completed, the duty works supervisor should pass them personally to day shift regional staff for follow-up action in the morning of the next working day;

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(b) when handling cases received outside office hours each morning, the day shift regional staff should register every fault report in the logbook for ready checking and then distribute the reports to day shift regional team members for action. The team members concerned have to sign on the logbook to acknowledge receipt; and

(c) day shift regional staff receiving fault reports recorded outside office hours should check each report carefully, cross-check against outstanding cases passed by the duty works supervisor and ensure that they have been dealt with properly to avoid missing any case.

5. This Office observed that WSD had no clear guidelines for CTEC staff reference. Had there been guidelines similar to those in paragraph 4(a), CTEC staff would have informed the night shift standby duty staff of the two "minor" complaints and the day shift staff would not have misunderstood the position. However, the day shift staff had also been careless in not checking with the night shift colleagues.

6. Overall, The Ombudsman considered this complaint substantiated.

7. The Ombudsman made the following recommendations to the Director of Water Supplies –

(a) to incorporate the revised procedures in paragraph 4 into departmental guidelines for staff; and

(b) to equip staff (especially supervisors) better with computer knowledge to facilitate effective monitoring of complaint handling.

This case highlights The Ombudsman's role in ensuring that wrongs are righted.